EDITORIAL

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The Expanding or Shrinking Universe of the Hospitalist

In a minute or two the Caterpillar ... got down off the mushroom, and crawled away in the grass, merely remarking as it went, "One side will make you grow taller, and the other side will make you grow shorter."
"One side of WHAT? The other side of WHAT?" thought Alice to herself.
"Of the mushroom," said the Caterpillar.[1]

As a hospitalist of about 6 years, I enjoy hospital medicine and hope, over the course of my career, to see it develop into an increasingly respected, diverse, and influential specialty. There is abundant evidence that this is occurring, primarily through the praiseworthy efforts of the leadership and members of the Society of Hospital Medicine (SHM). Efforts to prove our value to inpatient care and align ourselves with quality improvement, as promoted early in the hospitalist movement,[2] are coming to fruition. However, I would like to raise a flag of concern; and this is based on my experience working as a hospitalist in 10 community hospitals in 5 states, including positions as a locum tenens hospitalist, staff hospitalist, medical director of a hospitalist group, and full-time teaching hospitalist for a community hospital residency program. I believe that hospitalists, particularly those working in community hospitals (approximately 80% of all hospitalists),[3] are currently at a critical crossroad, with the option of either actively expanding their clinical, administrative, and quality improvement roles or allowing these roles to stagnate or atrophy. As in any career, we are, like Alice, perched on a mushroom, one side of which will make us grow taller and the other side of which will make us grow shorter. Which side are we choosing in our careers as hospitalists?

Hospitalists currently have numerous opportunities to expand their clinical, administrative, and quality improvement roles and responsibilities (Table 1), and these opportunities are in full alignment with the mission statement of SHM: "to promote the highest quality of care for all hospitalized patients."[4] My concern is that, for one reason or another, hospitalists in some settings are shrinking away from roles that they could or should fill, and this is a trend that I believe could affect our specialty adversely over time and that we, as an organization, should find ways to prevent. Although family medicine and traditional internal medicine physicians who work in the hospital face similar challenges, if we as hospitalists wish to qualify one day as board-certified hospital medicine specialists, we are obligated to develop knowledge and skill sets that are truly unique to our profession.[5] Holding to this goal, we cannot settle into a narrow comfort zone. I believe that the development of the hospital medicine core competencies by SHM[6] was an important step in helping us define our intended reach, but even so, what

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TABLE 1
Potential Areas of Involvement for Hospital Medicine Groups

1. Quality improvement
   a. Participating in quality assessments, making and implementing plans for improvement, and assessing effects of interventions
   b. Assessing patient and family satisfaction with inpatient care and making and implementing plans for improvement
   c. Assessing primary care physician, emergency room, subspecialist, and hospital staff satisfaction with inpatient care and making and implementing plans for improvement
   d. Participating in the development and revision of clinical guidelines, pathways, and order sets to improve efficiency and uniformity of care on the basis of current evidence
   e. Developing multidisciplinary hospitalist rounds to improve the coordination and quality of care
2. Professional development
   a. Developing new areas of knowledge and skill, such as certification in geriatric or palliative care medicine
   b. Developing processes of peer review (including chart review or case review) to ensure quality and uniformity of care within the hospitalist group
   c. Developing a system of continuing medical education for the hospitalist group to keep abreast of the latest evidence-based guidelines
3. Expansion of services
   a. Developing an in-house procedure team to perform bedside procedures for other physicians
   b. Providing cross-coverage for intensivists or other subspecialists at night or on weekends
   c. Developing, participating in, and improving rapid response teams and cardiac arrest teams
   d. Providing care or coverage for additional clinical areas, such as long-term acute care hospital units or transitional care units
   e. Meeting with subspecialist groups to identify any inpatient needs they have that could be filled by hospitalists
4. Teaching
   a. Participating in the medical education of residents and medical students
   b. Participating in nursing education efforts
   c. Promoting hospital medicine topics by speaking at hospital grand rounds or other local continuing medical education venues
   d. Promoting community health by participating in community education talks or workshops
5. Utilization management
   a. Participating in utilization management committees
   b. Evaluating the length of stay and cost per case for specific diagnosis-related groups and making and implementing plans for improvement
   c. Demonstrating cost savings and overall value to the hospital
   d. Reviewing and improving clinical documentation to optimize hospital billing processes
6. Information technology
   a. Participating in the development and improvement of the electronic medical record system and the computerized physician order entry system
7. Administrative
   a. Strategically planning with hospital administration to determine areas of highest priority
8. Research
   a. Performing and publishing clinical research unique to the hospital setting

are the specific growth factors or inhibitors that are influencing the expansion or shrinking of hospitalists and hospital medicine groups?

On the basis of my observations, I believe that this problem is due in large part to a misalignment of incentives. Specifically, I believe that the expansion of hospitalist roles and responsibilities is often counteraligned with the bottom-line productivity goals of the group. That is, to maintain high productivity, a hospitalist has a tendency to minimize his or her role in ways that save time. For example, there may be a tendency to overuse subspecialty consultations, which can take away some of the burden of complex clinical decision making, or to quickly transfer patients that are sicker and require more time to a higher level of care (if available). There may also be a tendency to avoid performing inpatient procedures (a significant part of the core competencies) because of time constraints and the demands of a higher census. Excessively rapid rounding results, and this diminishes other claimed benefits of the hospitalist model of care: patient satisfaction, safety, quality, and communication. Length-of-stay measures also suffer as productivity exceeds the limits of efficient care. Moreover, in such a productivity-based environment, there is certainly no incentive for hospitalists to become enthusiastically involved in hospital committees, education, or quality improvement efforts, all of which are critical to the development of hospital medicine as a unique subspecialty. In essence, the incentive to expand one's role as a hospitalist in such a setting is almost completely absent, and I believe that this puts the future influence and reach of our specialty at significant risk.

Particularly as hospitals face increasing scrutiny about their quality and safety, and especially as the costs of hospital care increase and reimbursements threaten to decline, the value of hospitalists to the hospital has become different from that of all other physicians. Their value lies not in sheer productivity but in their ability to improve the cost, quality, efficiency, and safety of inpatient care simultaneously. If hospitalists settle into or are forced into a lesser role, hospital medicine will not be worthy of consideration as a unique subspecialty. Some of the remaining roles of the shrunken hospitalist may, at some point and in some settings, shift to nonphysicians,[7] with a decline in the ratio of physicians to mid-level providers in hospital medicine programs, and the jobs of some hospitalists will be effectively eliminated. Market forces will lead to improved training of mid-level providers, allowing hospitals to fill inpatient care needs in a more cost-effective way.

TABLE 2
What Is Your Reach as a Hospital Medicine Specialist?

Medical Condition	Potential Consult
Instructions: For each clinical condition, describe what testing and management of the condition that you, as a hospital medicine specialist, would independently perform before consulting the associated subspecialist. Identify what specific clinical findings would prompt a consultation. Also, ask yourself into which areas you could reasonably expand your clinical practice as a hospitalist with additional experience, training, or study.	
Abdominal pain	Gastroenterology Surgery
Abnormal electrocardiogram	Cardiology
Abnormal thyroid-stimulating hormone	Endocrinology
Acute renal failure	Nephrology
Anemia	Hematology Gastroenterology
Ascites	Gastroenterology
Atrial fibrillation, new or uncontrolled	Cardiology
Bacteremia	Infectious disease
Central venous access	Surgery Anesthesiology
Chest pain	Cardiology
Chronic obstructive pulmonary disease	Pulmonary
Delirium/mental status change	Neurology Psychiatry
Depression/anxiety	Psychiatry
Diabetes, uncontrolled	Endocrinology
Diabetic ketoacidosis	Endocrinology
Diarrhea	Gastroenterology
End-of-life care	Palliative care
Fever	Infectious disease
Gastrointestinal bleed	Gastroenterology
Grief	Chaplain
Heart murmur	Cardiology
Hematuria	Urology
Hypercalcemia	Endocrine
Hypertension, uncontrolled	Cardiology Nephrology
Hyponatremia	Nephrology
Hypoxia/respiratory failure	Pulmonary
Infection	Infectious disease
Joint effusion	Orthopedics Rheumatology
Kidney stone	Urology
Meningitis	Infectious disease
Neutropenic fever	Hematology/oncology
Nonsustained ventricular tachycardia	Cardiology
Nose bleed	Ear, nose, and throat
Pain	Pain management
Paroxysmal supraventricular tachycardia	Cardiology
Pleural effusion	Pulmonary
Preoperative clearance	Cardiology Pulmonary
Pulmonary embolism	Pulmonary Hematology
Rash	Dermatology
Stroke	Neurology
Syncope	Neurology Cardiology
Thrombocytopenia	Hematology
Unstable angina	Cardiology
Urinary retention	Urology
Venous thromboembolism	Hematology

Having worked with some very capable nurse practitioners in 4 different community hospitals, I believe that a well-trained mid-level provider, with appropriate physician backup, can effectively manage many of the typical general medical admissions and surgical consultations seen in a community hospital setting. I admit that this may not be the case in larger referral centers or academic medical centers.

In developing and defining this new specialty and also in training new physicians for the field, we do not want to lose this transient opportunity to define ourselves as broadly as possible, pushing beyond traditional internal medicine to new areas of inpatient care and management and managing more complex conditions than a traditional primary care physician would typically manage, conditions that have always fallen within the broad spectrum of inpatient internal medicine (Table 2). If we instead develop a tendency to "admit, consult, and walk away" and do not have the time or appropriate incentives to expand our roles in other important ways (noted in Table 1) because of a focus on productivity, what is our specialty destined to become?

That said, how can incentives be restructured to encourage hospitalists to expand their universe? Perhaps the simplest way of influencing the incentive structure of hospital medicine programs is more selectivity in the choice of jobs: seeking out jobs that offer us clear incentives (typically financial) to expand our universe by rewarding efforts to improve the quality, safety, and efficiency of inpatient care. According to the SHM 2005–2006 survey, about two-thirds of responding hospital medicine programs reimbursed their physicians with a mix of salary and productivity/performance bonuses, with productivity being the dominant incentive (more than 80%). However, bonuses based on quality/efficiency measures were also being rewarded (about 60%), as well as bonuses for committee or project work (about 25%). Of all responding groups, that leaves about 60% of programs with no financial incentives for quality/efficiency measures. There is certainly room for progress in this area, and we can influence the process positively by requesting that such incentives be added to our contract before making a final commitment to a job or by negotiating changes to our current incentive structure at the time of contract renewal. This would be in the best interest of our individual careers as well as our specialty.

As we consider different job opportunities, we may also wish to consider the possible effect of the employment model on the incentive structure. Although it may seem logical that hospital-employed groups would have broader goals than independent groups and thus might be more motivated to provide proper incentives, I do not believe that this is the case universally. Conversely, private groups who might be expected to focus more on productivity measures may actually offer excellent growth-promoting incentives. In either case, careful consideration of the incentive structure is warranted when we choose to work in a given employment model.

Perhaps another way of encouraging hospitalists to expand their role would be through a program of national recognition, potentially established by SHM, that would allow individual hospitalists to formally claim specialization in a particular area of hospital medicine and benefit from such distinctions. For example, a hospitalist that was particularly proficient with inpatient procedures could submit documentation of procedures completed in a given time period and subsequently receive a formal designation as a certified procedural hospitalist or something similar. Alternatively, a hospitalist who preferred to focus on quality improvement efforts could submit information regarding his involvement with quality improvement initiatives and results and, on the basis of defined criteria, receive a formal designation as a quality improvement hospitalist. This approach could apply to any area of focus, and more than one designation could be achieved by each hospitalist. As the specialty of hospital medicine matures, these designations (similar to academic rank) could eventually correlate with salary ranges or incentive bonuses as hospitals learned to value the diverse skills of individual hospitalists.

Discouraging overconsultation of subspecialists while concurrently encouraging the broadening of our clinical skills is particularly difficult to address. The only solution to this issue that I can imagine would be to somehow align physician reimbursement more closely to the actual complexity of and time spent in managing patients with multiple comorbidities. Currently, the actual hospitalist physician reimbursement for subsequent visits of patients, with or without subspecialists involved, likely does not vary much. However, if hospitalists knew their extra effort in managing more complex conditions would be reimbursed differently (ie, billing for critical care time), they would certainly tend to broaden their practice to the benefit of their careers and the future of the specialty.

In summary, I believe that misaligned incentives are causing some hospitalists to underestimate their potential; this has the potential to adversely affect the future of the specialty of hospital medicine. I hope that this opinion will serve to generate discussion on the potential origins of and solutions to this problem and ultimately promote the future expansion of our hospital medicine universe, so that we do not find ourselves in Alice's predicament:

"Well, I should like to be a LITTLE larger, sir, if you wouldn't mind" said Alice: "three inches is such a wretched height to be."[1]

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